BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

BRYAN A. GUNNOE, M.D.

Holder of License No. **22817**
For the Practice of Allopathic Medicine
In the State of Arizona.

Board Case No. MD-03-1273A

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

(Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on April 13, 2005. Bryan A. Gunnoe, M.D., ("Respondent") appeared before the Board without legal counsel for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following findings of fact, conclusions of law and order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 22817 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-03-1273A after receiving notification of a medical malpractice settlement involving Respondent's care and treatment of a 53 year-old male patient ("RW").

4. On August 21, 2001, RW presented to Respondent complaining of severe left neck and shoulder pain. Respondent's preoperative evaluation indicated an anterior cervical discectomy and fusion was necessary at the C6-7 level, however, when Respondent subsequently performed the surgery he operated at the C5-6 level. RW ultimately underwent a second surgery at the C6-7 level.

5. At the formal interview Respondent testified RW's neck pain indicated a possible problem from degenerative changes in the neck, with pain being a product of the disk degeneration. Respondent noted the radiation of the pain into the shoulder led him to suspect there might be involvement of the nerve root. Respondent was asked the significance of his entry in RW's record under "History of Present Illness" where he wrote "[c]urrently he is complaining as noted of severe disabling pain in the left side of the neck that radiates all the way down into the hand, particularly on the radial border. He has numbness and tingling in the radial border of the hand." Respondent testified RW's information suggested he had root involvement in that the pain radiated in a distribution consistent with a nerve root dermatone. Respondent noted he was thinking C5-6 was the problem area with the C6 nerve root being involved. Respondent was asked if there were C6 nerve root involvement where specifically would the dermatone be. Respondent testified the 6th nerve root would be on the radial border of the hand with radiation into the first web space and long finger and index finger and the C5 root would be the deltoid distribution up in the arm.

6. Respondent was asked if, based on the History of Present Illness, he was looking for a C6 lesion. Respondent testified he was. Respondent was asked what nerve root he was looking at when he noted in his physical examination, specifically addressing motor strength testing, that he found "symmetry of the deltoid and biceps, weakness at triceps and four out of five weakness of external rotators of left shoulder. He has definite pinprick hip esthesia at what appears to be C6, possibly C7 distribution in right arm." Respondent testified it would be C6, deltoid is C5, C6 for the biceps, C7 for the triceps. Respondent testified he did not use external rotators so much to determine which nerve root level that is, because he does not find it to be such a definite indicator of

which nerve root is involved, as opposed to C5 where it is almost exclusive C5 enervation of the deltoid or the biceps where it is strongly C6, and then triceps is pretty strongly C7.

7. Respondent was asked what deep tendon reflex would correlate with his presumptive diagnosis of a C6 lesion. Respondent testified the brachial radials would. Respondent was directed to his record for RW where no reflexes were noted and was asked if it was important to note reflexes when diagnosing a patient with radiculopathy. Respondent testified it was absolutely important and the standard of care is to delineate in patients with radiculopathy what their reflexes would be. Respondent noted he was only going from 20/20 hindsight from the records of four years ago, but from his definite routine when he examines the patient involves testing the motor strength sequentially and also at the same time testing all of the reflexes. Respondent testified he suspects it is a matter of his not recording what he did, rather than his not doing it because when he looks at a patient and he is thinking about possibly doing something as invasive as surgery, he would not miss the opportunity to check reflexes – doing so is part of his routine.

8. Respondent was asked to explain the handwritten notes/corrections in RW's record under "Radiology." Respondent testified there was some inconsistency because under "Radiology" he had crossed out "C5 and C6" and put in "C6 and C6" when he should have put in "C6 and C7." Respondent stated that when he wrote the Assessment he originally thought or originally put "C5-C6," but went back and changed it two weeks later to "C6-C7." Respondent stated the changes in his documentation are where he ultimately decided where the problem was in a C7 distribution, not a C6 distribution.

9. Respondent was asked if it was his habit in the Radiology section to personally look or to refer to the radiology report that accompanies the MRI. Respondent

testified he did both. Respondent was asked if when he wrote "[a] large acute herniated disk between the levels" was it based on the radiologist's interpretation or his own interpretation. Respondent testified that he normally indicates in his notes whether it is his or the radiologist's interpretation, but he failed to do that in RW's record and is unable to tell exactly whether it is his or the radiologist's opinion. The Board noted the radiologist's note under "Impression" was "broad based bulging and spurring, slightly eccentric to the left side" and did not mention anything about a large disk impinging on the nerve roots. Respondent testified the challenge in RW's case was that there were two levels of disk degeneration and spurring, both at C5-6 and C6-7 and Respondent's goal was to address what he thought were the most severe symptoms, radiculopathy, and he wanted to avoid doing a two-level fusion because as he looked at both the plain films and MRI, it was clear the degenerative changes were not acute and had been there for some time. Respondent noted there was something that had happened to account for the relatively new onset of radiculopathy and his challenge was to decide which level it was coming from and it was a very difficult decision process for him, based on the physical findings and MRI, which level was the symptomatic level.

10. Respondent testified one of the reviewers who looked at RW's case opined he would have done a two-level fusion from the very start, reflecting the difficulty of deciding which level it was or that perhaps there would be problems later on at the superadjacent or subadjacent level. Respondent stated in RW's case he felt he had delineated the proper nerve root to decompress, however, the second issue when he actually got in the case and decided which level to go at, he made an error in counting the disk spaces. Respondent testified that as he palpated RW's neck, there were prominent osteophytes, both at the C5 and C6 level and he initially placed the needle marker too low on an intra-operative lateral x-ray and then replaced the needle in what he

thought was the proper disk and proceeded with the discectomy at that level, having miscounted.

11. Respondent testified he was not sure if the issue for the Board was his deciding to operate on the wrong disk in terms of intention or that he ended up operating on the disk different from what he intended. Respondent noted the latter represents a breach of standard to perform an operation at a level other than what he intended. Respondent was asked how it was brought to his attention that he had operated on the wrong level. Respondent testified after the radiologist viewed the films the next morning he called Respondent. Respondent stated he went down and talked to the radiologist and looked at the films and counted it out and realized it was at the wrong level. Respondent testified when he first spoke with RW post-operatively, RW expressed pleasure that the pain in his arm was gone. Respondent noted while he knew he had operated on a level he had not intended to, he did not feel it was appropriate to say anything to RW at that time because he was experiencing pain relief and Respondent wanted him to go home happy. Respondent testified he told RW at the first post-surgery follow-up appointment that he had performed the surgery at the wrong level. Respondent stated RW told him that whatever Respondent had done had relieved the pain.

12. Respondent was asked when was the right time to tell the patient he had operated on the wrong level if it was inappropriate to tell the patient when he saw him post-operatively. Respondent testified he could have told RW immediately that first post-operative day and created some fear and anxiety for RW as to whether he would need further surgery, what it would mean to him ultimately, and would there be morbidity from the operation beyond the pain that Respondent had asked him to expect in his neck and from the graft site. Respondent stated it was a decision based on the circumstances that frankly, he did not want to interrupt RW's sense of having relief after going through all of

the months of pain and he chose to allow RW to enjoy the pain relief. Respondent testified his intention was not to hide his mistake, but he just made a bedside decision that it was not the best time to tell RW. Respondent was asked how the circumstances differed when RW presented for his first pre-operative visit at Respondent's office. Respondent noted it was a bit different because the first post-operative day is still in the hospital and RW still had tubes and drains in him, and a fresh dressing. Respondent also noted that RW would have had a sense of relief that he made it through what could be a potentially dangerous surgery. Respondent testified that after having been home and getting back to a routine for a few days, having a chance to sort out whether the pain relief was from the medications or is indeed gone, RW would have been in a better state of mind to discuss the error.

13. Respondent was asked if it was important to document in the chart that the surgery was performed at the wrong level. Respondent testified it was. Respondent was then asked why, in his operative note, he wrote "Complications, none.". Respondent testified the operative summary dated August 22, 2001 lists as complication "anterior cervical discectomy" and says "infusion" when it should have said "fusion" performed at C5-6 whereas the preoperative intention was to perform anterior cervical disk fusion at C6-7. Respondent was asked the date of dictation of this note. Respondent testified it was dictated August 24, 2001. Respondent was asked if it was correct that during the dissertation regarding the different site surgery or wrong level it mentions that dictation was done within twenty-four hours when that does not seem to be accurate. Respondent testified the dictation was not done within twenty-four hours. Respondent asked if there was any mention on his discharge note that the error occurred. Respondent was asked specifically to review his notes from rounds that day that do not mention the error. Respondent testified that looking back at the case, he realizes was so taken aback by

performing a wrong site surgery and when the radiologist told him he had and he looked at the films himself, he was in a state of shock that he could make such an egregious error. Respondent testified he did not know what to do because he had never done this before, and in looking back, you can see hesitation, first by way of the operative report being later than 24 hours and looking back he can remember agonizing over it. Respondent noted that even though RW said he was better, it was clear he had done a different procedure than he was supposed to do and it needed to be documented. Respondent noted it took him two days to get it together and write down exactly what he had done.

14. Respondent was asked how his practice has changed since 2001. Respondent testified a lot has happened to him since 2001. Respondent noted in 2001 he was a year into his recovery and still had quite a bit of difficulties with anger and resentment. Respondent noted that some Board Members may well remember him being before the Board during that time for compliance issues. Respondent testified there was also manifest in his behavior towards the hospital arrogance and independence that was an effort to keep people out because he was afraid of what he had done in his life and was reluctant to seek help. Respondent noted he had an overall attitude that he knew what he was doing and could do it by himself – an "I'll show you" attitude. Respondent testified a consequence of his behavior was losing his position at the hospital and leaving his practice. Respondent also noted he faced censure before the Board and censure with the American Board of Orthopedic Surgery because of his actions.

15. Respondent testified that the consequence has been over the long run that it took him more than one year to find a job again and in the intervening time he has learned a lot about his behavior and attitudes that seem to be self-destructive.

Respondent testified in his protocol in his practice is to get wet reads in the operating room and not rely on his eyes for something so critical as deciding the appropriate level, which is a challenge in spine surgery. Respondent testified he is willing and anxious to seek help and his aloofness and arrogance and anger has to some degree been knocked out of him. Respondent testified he has not had the opportunity to perform another anterior discectomy fusion so he cannot prove his protocol, but it is fully his intention to avail himself of all resources to make sure the right thing is done for the patient and not for himself.

16. Respondent was asked how he placed a needle into the intervertebral disk space. Respondent testified that the first intra-operative lateral x-ray determines the location of the incision by putting a metallic marker on the neck and taking the x-ray. Respondent noted once the decision is made about where to make the appropriate incision, he makes the incision and goes down and palpates the vertebrae. Respondent stated when he thinks he has the correct vertebrae he takes the spinal needle, so it does not damage the disk if it happens to be at the wrong level, and puts it in and looks where the needle is and counts again. Respondent stated if he determines he is at the correct level he will go in with electric cautery and make a mark in the disk, across the disk, to be sure he continues to operate at the proper disk level. Respondent testified he puts his finger on the tip of the needle and either has handrail retractors put in and go directly down while he is holding the needle in place and electrocauterize right where it is. Respondent testified that during his fellowship and residency he was not trained to wait for a wet read before proceeding. Respondent noted this case taught him his training was not in the patient's best interest.

17. Respondent testified that when he looked at the first x-ray he saw the marker was in the wrong space so he went back in. Respondent clarified that at the time

of the first x-ray he used a superficial marker. Respondent was asked if at the time of the first x-ray he learned he was in the wrong place. Respondent testified he did not because the incision is not as exact and you can ct an incision three-quarters of an inch up or down and still very adequately get to the disk space that you need to. Respondent noted his second x-ray was a needle, but at the wrong space. Respondent was asked to describe the third x-ray. Respondent testified he went back, replaced the needle in the superadjacent space and took another lateral x-ray and began the operation without a wet read on the replacement needle. Respondent testified he looked at the x-ray while he was operating, but never obtained a wet read – the films went from being taken, to the developer, to the operating room, but never before a radiologist until after the surgery.

18. Respondent testified that, although RW ended up with vocal cord paralysis, RW did not appear to have a vocal cord problem post-operatively or when he came for his first post-operative visit. Respondent testified he believed RW had subsequent surgery for his neck and an injection into one of his vocal cords.

19. The standard of care during surgical treatment for spinal problems requires a greater effort of determination of the appropriate level section that should be confirmed intra-operatively.

20. Respondent deviated from the standard of care because he determined preoperatively that surgery was required at the C6-7 level and surgery and, because he did not confirm the appropriate level section intra-operatively, he performed the surgery at the C5-6 level.

21. RW was harmed because the surgery was performed at the wrong level requiring him to undergo an additional surgery.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence, or negligence resulting in harm to or the death of a patient.")

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED that Respondent is issued a Letter of Reprimand for failure to confirm the appropriate level section intra-operatively resulting in his performing spinal surgery at the wrong level.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-102. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 9th day of June, 2005.

THE ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 9th day of June, 2005 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Certified Mail this 9th day of June, 2005, to:

Bryan A. Gunnoe, M.D.
Address of Record

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